UNIVERSITY of WASHINGTON
HUMAN SUBJECTS DIVISION
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HIPAA Authorization

For the Use of Patient Health Information for Research

Research Title: Medicaid Asthma Home Visit Project-Improving Health and Reducing Costs of Health (MAP)

Lead researcher: James W. Krieger, MD, MPH

Institution of lead researcher: Public Health Seattle-King County

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your patient health information. Your patient information will be used to do the research named above.

This document is also used for parents to provide permission to obtain the patient information of their minor children, and for legally-authorized representatives of subjects (such as an appropriate family member) to provide permission to obtain patient information of individuals who are not capable themselves of providing permission. In such cases, the terms "you" and "your patient information" refer to the subject rather than the person providing permission.

State and federal privacy laws protect your patient information. These laws say that, in most cases, your health care provider can release your identifiable patient information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The patient information that will be obtained and used

"Patient information" means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

1. Location of patient information

- By signing this form you are giving permission to the following organization(s) to disclose your patient information for this research.

Name of health care organization(s) or provider(s): Community Health Plan of Washington (CHPW) and Molina

Other: _____

2. Patient information that will be released for research use

This permission is for the health care provided to you during the following time period: from the date you sign the consent form to the end of the study.

The specific information that will be released and used for this research is described below:

- Medical history / treatment
- Asthma status over past 14 days
- Medical visits, planned & unplanned since last CHW visit
- Medication use and technique
- Asthma action plan use
- Household asthma triggers
- Individual identification numbers: health plan number and Medicaid number such as PIC#
- Names (child and parent or legal guardian
- Demographic data: date of birth, gender, race/ethnicity, and primary language
- Address
- Phone numbers
- Primary care clinic name and provider name
- Dates of hospitalization, ER visit, clinic visit, and medication filled
- Medication data: medication filled, date filled, quantity, and days of supplies
- Claims data: data of service, CPT code, amount billed and amount paid, payer (DSHS vs. insurance vs. self)

C. How your patient information will be used

The researcher will use your patient information only in the ways that are described in the research consent form that you sign and as described here.

The research consent form describes who will have access to your information. It also describes how your information will be protected. You can ask questions about what the research team will do with your information and how they will protect it.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

D. Expiration

This permission for the researchers to obtain your patient information ends when the research ends and any required monitoring of the study is finished. This is expected to be August 31st 2015.

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to:

Marissa Brooks, MPH
King County Asthma Program
401 Fifth Avenue, Suite 900
Seattle, WA 98104-1818

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will need to leave the research study. This means that you would not have any more research study home visits. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

F. Giving permission

You give your permission to release your information by signing this form.

Printed Name of Research Subject **(Child)** Birthdate

Signature of Research Subject **(Child)** Date of signature

Printed Name of Person Authorized to Give Permission **(Parent/Guardian)**

Signature of Person Authorized to Give Permission **(Parent/Guardian)** Date of signature

Relationship to Subject and Description of Authority
(Examples: parent / guardian / caretaker of child)

You will receive a copy of this signed form. Please keep it with your personal records.